Inquiry into the Transition of the Commonwealth Home Support Program to Support at Home

A Dementia Australia submission

February 13, 2026

Dementia in Australia

Dementia Australia is the peak body representing the estimated 446,500 people living with dementia and their carers across Australia. Dementia prevalence in Australia is set to increase to more than a million people by 2065 [1, 2].

Dementia is the leading cause of death for all Australians, as well as a leading contributor to disease burden [1].

The majority of people living in permanent residential aged care have dementia or cognitive impairment. People living with dementia may be supported in a memory support unit or dedicated dementia service but are also commonly cared for in the general aged care system [1]. Quality of home supports is also critical, given that around two thirds of people living with dementia live in the community [1].

People living with dementia access a range of supports through the Commonwealth Home Support Program (CHSP). We also know that people with dementia with more complex needs (beyond the intended scope of the CHSP, as an entry level program providing a low level of support) utilise CHSP support as stop gap when they are unable to access an appropriate level home care (now Support at Home) package or while they are awaiting assessment for a package.

There is no data on the number of people living with dementia who currently access both the CHSP and Support at Home (SAH) programs. Given this data gap, it is unclear what services are being received, if they are meeting the needs of people living with dementia or the potential level of continuing unmet demand.

Expertise of living experience

In preparing this submission, Dementia Australia surveyed and consulted people living with dementia, and dementia carers, who are members of a large national network, known as Dementia Advocates. We have also gathered information about the impact of the new Aged Care legislation from callers to the National Dementia Helpline and from clients accessing our post-diagnostic support services.

All quotes are de-identified, verbatim responses from people living with dementia or carers.

Introduction

Dementia Australia welcomes the opportunity to make a submission to this Inquiry into the Transition of the Commonwealth Home Support Program (CHSP) to the Support at Home (SAH) program. As the peak dementia advocacy organisation in Australia, we amplify the voices of people living with dementia by sharing their stories and helping inform others. As the trusted source of information, education, and support services, we advocate for positive change for people living with dementia, their families, and carers, and support vital research across a range of dementia-related fields.

Dementia Australia is also a provider of CHSP services in the ACT, Queensland, Tasmania, and the Northern Territory delivering respite, transport, and social support. Our submission will therefore address the impacts of the proposed transition from both a systemic advocacy and service provider perspective.

Dementia Australia supports the recommendation from the Royal Commission into Aged Care Quality and Safety identifying the need for a streamlined and integrated system of home care service provision consistent with the Commission's intent for a single, combined program that retains the benefits of its existing component programs and delivers support based on assessed need. However, Dementia Australia is concerned that the new Support at Home model does not embed the flexibility and responsiveness required to support the independence and meet the needs of older people, particularly people living with dementia and those caring for them at home. The transition to SAH must be informed by comprehensive consultation with the aged care sector, older people and their families, and clear communication of the processes and timeframes involved.

1. Timeline for transition after 1 July 2027

There are number of factors that make the CHSP transition more complex than the transition of the home care program into SAH. These need to be acknowledged and reflected in implementation planning and timeframes.

The SAH program is not in steady state

The transition of home care to SAH will take some time to bed down and to identify and address any unintended impacts and consequences. It is critical that sufficient time is allowed, and feedback sought from participants and providers, to evaluate if the current issues relate to the transition or systemic issues with the SAH program design. Either way these issues need to be rectified before the CHSP transition can commence.

Current SAH issues impacting people living with dementia include:

- Concerns about consumer contributions, rising costs and financial barriers to accessing care
- Assessment wait times
- Assessment outcomes including classifications and allocated support not meeting needs
- Wait times for accessing services
- System complexity and the need for navigation support to help understand information and options
- Concerns about staff availability, turnover and dementia capability
- Availability of services including respite

Dementia Australia has significant concerns about financial impacts for people with dementia under the current SAH co-contribution arrangements. It is critical that people living with dementia and those caring for them receive appropriate services and support to maintain their social connection, independence, and ability to continue to live at home.

The means-testing basis of the SAH co-contributions means costs will vary depending on types of services you receive and your means. This disproportionally disadvantages people living with dementia given higher co-contribution rates for independence (e.g. social support, transport and personal care) and everyday living services (e.g. domestic assistance, meal preparation and shopping) which are key to maintaining wellbeing and independence for people living with dementia and have been shown to have a therapeutic effect.

Higher costs for these services are resulting in increased financial strain for people living with dementia and may result in people opting out of receiving these services leading to significant downstream impacts in terms of avoidable admission to the already overburdened acute and residential aged care sectors.

Consumer behaviour patterns must be closely monitored in this early phase of SAH, and on an ongoing basis, to track if people are opting out services and the individual and system-wide impacts of this.

CHSP clients are likely to be currently receiving services and supports from multiple providers. In transitioning to SAH, should the single provider model be retained, many people will need to change to a provider that offers all the services they need or be subject to subcontracting arrangements, adding to the complexity and costs for both providers and participants.

Additionally, if some services remain block funded (as supported by Dementia Australia) while the bulk are individualised and attract a co-contribution, this will add a further layer of complexity to funding and administrative arrangements.

Size of transition

In 2024–25, the CHSP supported approximately 839,000 people [3]. Therefore, the CHSP transition will impact around four times as many older people as the home care program so a significantly longer transition timeframe will be required.

Additionally, there are more CHSP providers (1,330) than home care providers (923) that will be impacted by the transition [4]. CHSP providers also vary more in size and capacity, including many smaller volunteer-run providers who are less well equipped to plan for and negotiate the transition. They will need extra time and support to be transition ready or assistance to transition clients to alternate providers should decide they are unwilling or able to continue as a SAH provider. This transition process not only impacts the providers, but adds to the level of confusion, complexity, and system navigation that people impacted by dementia will be expected to shoulder over that period.

Providers and clients will need significantly more time to understand the changes involved and prepare for the transition than was provided for SAH. This is critical to ensure there is a more orderly transition to SAH. Consultation with Dementia Australia clients highlighted that:

- the majority (53 per cent) did not understand what the changes introduced on November 1, 2025, meant for them,
- most (53 per cent) did not feel confident they could access the aged care services they need,
- many (48 per cent) did not expect to be able to afford the care services they need.

Feedback also described confusion, lack of clear information, and reports that even providers and My Aged Care staff were unable to explain the changes. These findings underscore the importance of well-planned and timed transition underpinned by early and thorough consultation.

There are also more fundamental differences between CHSP and SAH, which will require more complex policy and program design and implementation considerations, for example:

- requirement for simple vs complex assessment,
- block funded by service vs individualised budget
- no formalised care management vs compulsory care management capped at 10 per cent of SAH package

Client transition needs

Two thirds of Dementia Advocates surveyed were aware of the CHSP transition to SAH, but many were uncertain about what the transition might involve. Nearly 70 per cent of survey respondents were concerned about the transition, particularly their personal preparedness for the transition and the need for a realistic timeframe in which to understand and adjust to changes.

Survey responses showed a clear consensus on the need for information about the program transition that was timely and clearly expressed in plain language that all older people and people with cognitive impairment and their families could understand.

"Clear, simple communication about what will change and what will stay the same. Reassurance that people living with dementia will not lose services, and that familiar routines and support workers can continue. Having a consistent contact person or helpline to guide you through the transition would help you feel confident and supported." Carer

"People living with dementia need stability, simplicity, and continuity. Any transition must avoid sudden changes to routines, providers, or eligibility. The system should not assume people can navigate complex forms, portals, or assessments on their own. Clear communication in plain language, support for carers, and guaranteed continuity of familiar workers are essential. Assessments must be dementia-aware, trauma-informed, and not rushed. Without these considerations, the transition risks causing confusion, distress, and loss of support for those who are already vulnerable." Carer

Recommendations

That the transition from CHSP to SAH should not be tied to the current timeline of 'not before July 1, 2027' but based on ensuring that:

- existing SAH transition issues, including those identified above, are resolved;
- outstanding design elements are identified and resolved to enable CHSP services to be integrated without increased program complexity and unintended consequences;
- transition activity is thoroughly planned and realistically timed; and
- sufficient provider and client communication is provided;

before transition of CHSP commences.

2. The expected impact of this transition

a) Waiting periods for assessment

The CHSP has been effective in supporting older people to remain at home, often preventing unnecessary admission to acute care and premature entry into residential aged care. The program offers a safety net, providing funding and support when people are unable to access the support they need through an individualised package, respite or other aged care services including residential aged care. People use the CHSP to 'top up' the gap between their care needs and what can be readily accessed through other aged care programs, as acknowledged and endorsed in certain circumstances in the SAH Program Manual.

As noted above, there are approximately 839,000 people currently receiving CHSP support. Given these existing clients do not have individualised budgets, their support needs cannot be directly mapped to the nearest SAH package level. It is assumed that all existing CHSP clients will need some form of reassessment. This would necessitate timely access to assessment by a large, appropriately trained assessment workforce that understands dementia, with the ability and authority to apply clinical judgment to ensure appropriate assessment outcomes. Assessors must have the opportunity to override the Integrated Assessment Tool (IAT) assessment outcome where necessary, to ensure people transitioning are not placed in an inappropriate level of care or denied access to care. The need for a dementia diagnosis by a specialist (neurologist or geriatrician) in the current assessment process must also be reconsidered as an urgent priority. This does not reflect current practice, where many people are appropriately diagnosed by other clinicians, including for cost and access issues.

Given the current lengthy wait times for assessment, a significantly expanded workforce must be in place before CHSP clients start to transition to avoid a further blow out of assessment wait times.

If CHSP is transitioned and access to the SAH program is not significantly improved, the impacts will include additional physical, emotional, and financial challenges for people living with dementia and their carers. Lack of access to appropriate support for people living with dementia will also result in unnecessary admissions to acute care as a measure of last resort. This will exacerbate the existing crisis in hospitals for older people, including those living with dementia, many of whom are clinically ready to be discharged but are unable to access appropriate home or residential aged care.

Waiting periods for service provision

Dementia Australia also has concerns in relation the potential reduction in support and services for existing CHSP clients if transitioned to the SAH program. Advocates report experiencing increasing wait times for both assessment and access to a SAH package, as well as the fees increasing due to co-contributions.

Feedback from people living with dementia and their carers currently accessing CHSP, consistently described delays of many months in accessing assessments or services. Nearly 50 per cent of respondents waited for assessments or reassessments; the most common wait time was 6–12 months (33 per cent) with a considerable number waiting over 12 months (15 per cent). Similarly large numbers waited for additional in-home support services; of the 35 per cent waiting for these services, 21 per cent were waiting for Support at Home services and 14 per cent for more CHSP support. Tellingly, many of those waiting believed they did not have sufficient support in the interim (40 per cent).

People living with dementia can experience rapid and variable changes in the progression of their disease, necessitating prompt and responsive changes in care and support. The need for timely assessment, reassessment and provision of appropriate services is critical in this context.

“As dementia increases the carer needs increasing support. There doesn't seem a recognition that the client needs can change rapidly, and so carer needs quick response of support.” Carer

Survey respondents reported that reassessments did not result in more timely access to increased support, so they remained in prolonged queues despite their needs being urgent. Others described being forced to pay privately or go without essential care. The potential impacts of current wait times include missing out on required services including allied health and other services that are important for maintaining physical and cognitive wellbeing. This in turn places additional challenges on family carers who often already under considerable strain and stress.

Respondents consistently noted that the CHSP’s flexibility was an important benefit of the current program. This includes accepting people prior to assessment in certain circumstances, receiving service adjustments without reassessment, and having immediate access to respite. There was widespread concern that the transition to SAH and different requirements of the SAH model would result in reduced responsiveness and flexibility.

There is widespread concern that the move to SAH may result in higher costs, reduced services and flexibility in service provision including the ability to waive fees, and more means-testing, all of which pose significant risks for people living with dementia, on low incomes or self-funded retirees with limited liquidity.

“Much higher fees. CHSP was an affordable fee structure - the new program will be means tested." Carer

‘Losing current services’ was the predominant concern expressed by survey respondents who emphasised that transition to SAH must preserve CHSP’s core strengths of flexibility, low cost, social connection, and immediate access to services.

Recommendations:

- A rigorous cost-benefit analysis of the transition from CHSP to SAH must be conducted to ensure that the proposed economic benefits are demonstrable and sustainable. The analysis must evaluate the financial impact on existing clients transitioning to SAH to assess the extent to which the ‘no worse off principle’ has been upheld in practice.
- Embed the flexibility and responsive features of the current CHSP into the SAH program including assessor ability to apply clinical judgment when assessing clients, provision of services up front while waiting for assessment/reassessment. This is particularly vital for people living with dementia with complex and variable needs to ensure they receive timely and appropriate services and support.

b) The lifetime cap of $15,000 on home modifications

Dementia Australia considers the $15,000 cap on home modifications under SAH cap does not reflect the true cost of home modifications and is particularly inadequate as a lifetime cap. Home modifications enable independence and maintain a person's ability to remain living at home and are particularly important to support a person living with dementia and their carer in this context. Delaying access to home modifications or limiting funding will have potential impacts on wellbeing, quality of life and the ability of a person living with dementia to stay at home. Given the average Commonwealth Government cost per resident per annum (approximately $90,000), increasing the proposed $15,000 cap would represent a strong return on investment [5].

The needs of people with dementia can change rapidly and unpredictably. Access to a range of home modifications over time must reflect these changing and progressing needs, including safety equipment, bathroom modifications, mobility supports, sensor technology, and environmental adaptations. Many survey respondents stated that the cumulative cost of different home modifications over time would exceed $15,000, particularly given that authorised suppliers often charge more than private providers.

Recommendation:

- The $15,000 lifetime cap under SAH needs to be significantly increased to provide the appropriate range of home modifications over time to support a person living with dementia to live safely at home for as long as possible.

c) The End-of-Life Pathway time limits

As a new stream of support, the End-of-Life Pathway funding is a welcome inclusion in the SAH program. However, the limit of $25,000 over 12 weeks for tailored in-home care for individuals with 3 months or less to live is often not appropriate for people living with dementia, whose disease trajectory and symptomatology is variable. Even the potential extension of support to 16 weeks may not be adequate in meeting the needs of a person living with dementia who may require additional support for an extended period.

End-of-life care needs and timeframes for people living with dementia are not predictable or uniform. Large cohort evidence shows that clinicians are reasonably accurate at identifying people with dementia who are imminently dying or likely to live more than a year but are poor at predicting intermediate survival of weeks to months [6].

Rigid time limits and capped funding risk penalising individuals who outlive expected timeframes. Existing CHSP arrangements have enabled providers to respond more quickly and flexibly at the end of life as a result of block funding by scaling supports up or down as needs change without a time limit on additional supports or the need for additional applications or reassessment.

This is often in combination with access to state-based palliative care services. If a person outlives the clinicians' expected timeframe, it might require an application for additional support under a time-limited SAH End-of-Life Pathway, introducing administrative burden and delays and risking a step down in support at an extremely sensitive time.

Survey respondents made the same observations noting that setting both time-limited access and a flat cap on funding was inappropriate for someone living with dementia and with potentially complex and lengthy support and care needs at the end of life.

Recommendation:

- Detailed data on the adequacy of this cap within SAH for various client cohorts, including people living with dementia, should be collected and made available before a final decision on the time limit on support under the End-of-Life Pathway is made and applied to transitioning CHSP clients.

We will continue to seek feedback from Dementia Advocates and clients, our staff, and other stakeholders in monitoring the access and impact of the end-of-life care pathway.

d) Thin markets with a small number of aged care service providers

Every older Australian should have equitable access to services, regardless of where they live. Genuine choice requires that every older person has access to more than one provider. The issue of thin markets for aged care services has been a long-standing problem, particularly in rural, regional, and remote areas where people may have limited or no choice of service provider.

Dementia Australia Advocates reported often having only one provider in their region or none with capacity. 52 per cent of respondents in rural, regional, and remote areas reported only a few providers, ten per cent had only one provider and ten per cent had no access to any providers. Even in areas with multiple providers, availability was often limited, especially for respite, home maintenance, and out-of-hours care.

Advocates reported that limited provider availability affected their ability to get the support they need. 45 per cent of people living in rural, regional, and remote areas affirmed limited provider ability had an impact on their access to appropriate services and supports. Even if there was capacity for service provision, some respondents in rural and regional areas noted that services with appropriately trained staff were difficult to secure.

"Providers are available but trained and available staffing looks like being an increasing problem." Rural carer

"Haven't been able to get any help now from providers in my area so can't imagine anything will improve." Regional carer

Access to respite

Lack of access to various forms of respite care has been, and continues to be, a significant issue in the thin market context and was a consistent theme in feedback from Dementia Advocates. Limited respite availability including emergency, overnight or short stay respite was identified as a significant gap in current service provision. Carers described the toll of providing care, including physical and emotional exhaustion and juggling care responsibilities with their own personal health challenges, in the absence respite.

"Overnight respite was nearly impossible to get, especially at short notice and when highly stressed by dementia patient being up all night." Carer

"Carers need more respite services, also having a bilingual workforce would be an asset for organisations that provide services in these areas." Carer

Appropriate funding arrangements

Dementia Australia is concerned that the transition of CHSP to SAH may exacerbate existing inequities in service access for people living with dementia and their carers in regional, rural, and remote areas, particularly if block funding is not retained for some service types and in some markets,

Additionally, the Independent Hospitals and Aged Care Pricing Authority's SAH pricing caps that come into effect on 1 July 2026, must acknowledge the additional costs of delivering services in thin markets.

Not-for-profit providers often play a vital role in thin markets beyond actual service provision, supporting the health system, providing case management and employment to the local community. It is important to invest in and support these providers to ensure they remain viable, so they can continue to contribute to the health and social cohesion of rural and remote communities, including supporting people living with dementia and their carers to continue to live at home.

Recommendations:

- IHACPAs pricing of SAH services must reflect the accurate costs of service delivery in thin markets, for group services and for specific client cohorts including people living dementia.
- The setting of price caps should not be implemented without detailed data on the financial impact of SAH funding changes for clients and services and the resultant availability and uptake of services.

The setting of price caps should not be implemented without detailed data on the financial impact of SAH funding changes for clients and services and the resultant availability and uptake of services.

3. Provider and workforce readiness

Dementia Australia has a longstanding and ongoing commitment to advocating for the importance of a dementia-educated health care workforce who are competent and confident to provide high-quality dementia care. A genuinely rights-informed approach to the provision of support and care for older people living with dementia cannot be achieved without a skilled and capable aged care workforce.

People living with dementia and carers have told us that the skills needed for high-quality dementia care include empathy and person-centredness, well-developed communication skills, a commitment to quality care, and an openness to complaints. Aged care staff must have knowledge of specific types of dementia, their impact on an individual and how to provide tailored support and care. Aged care workers must be skilled in supporting individuals with changed behaviours, understanding the impacts of the physical and emotional environment, and responding appropriately to underlying causes of behavioural change.

Dementia Australia Advocates consistently reported that the aged care workforce currently lacks many of these attributes and the requisite knowledge and training to deliver high-quality care. Advocates also reported high staff turnover, inconsistent staffing, and lack of continuity of care as significant issues that influenced the safety and wellbeing of people living with dementia.

“Workers need to be trained in the area of dementia. A person with dementia needs stability with a worker, having different workers creates anxiety to the person that has dementia.”
Carer

Many Dementia Australia Advocates called for mandatory, dementia-specific training across all provider categories, with particular attention to smaller services that may lack capacity to meet strengthened standards without targeted support.

Dementia Australia is concerned that 18 months out from the earliest possible date for the transition, there is limited information on funding structures, entry pathways, or potential impacts on existing client services. The aged care workforce is already fatigued by years of ongoing reform and are still working to understand and embed new requirements under the Aged Care Act and transition to the SAH.

The transition of CHSP to SAH must not proceed until all outstanding issues with the SAH program have been resolved and a clearly communicated transition process is in place. Many smaller providers, constrained by variable IT systems and personnel, have already left the sector or are struggling to remain viable. This disproportionate impact on community-led, smaller providers has resulted in a sector increasingly dominated by larger, profitable providers who are more financially stable and able to absorb any potential risks. The longer-term impact of this market shift on quality of care and access to services for people with more complex needs, who are often considered higher risk and less financially profitable, remains to be seen. However, people living with dementia are particularly vulnerable in this regard.

Recommendations:

- Lessons learned from the home care to SAH transition should be embedded in the planning for the CHSP transition to ensure a smoother experience for all.
- Provider and client implementation readiness should ultimately drive the CHSP transition timeframe, and this should be communicated early to enable clients, particularly those with dementia, to be adequately prepared.
- Financial support to enable at risk providers to meet transition costs should be made available to ensure they can make the transition and implement new systems.
- Government subsidised and mandatory dementia training for the CHSP workforce should be expanded and promoted over the next 18 months, before providers prioritise transition preparation over essential dementia capability upskilling.

Block funding issues

As noted earlier in this submission, there are some fundamental differences between CHSP and SAH, which require more complex policy and program design and implementation considerations, including the issue of block funding   Dementia Australia supports retaining block funding of some services rather than an individualised budget. Existing CHSP services such as cottage respite, centre-based respite, meal services, and transport providers all have high overheads, and would be more viable outside an individualised funding model. Retaining block funding tor these services would assist in maintaining a minimal viable service, where and when service delivery outputs fluctuate, particularly in rural, regional, and remote areas.

This is particularly important for services that support people living with dementia whose capacity and ability to participate in group programs may differ day to day or week to week. Provider viability is a key concern; it can be challenging to operate without a block funded model allowing for the employment of staff and meeting of other operating costs. There are high fixed costs for all group activities. This would result in a further reduction in service availability and consumer choice for people living in rural and regional areas and or accessing group supports.

Recommendation

- Block funding be retained for some service types, particularly group-based services.

Thank you for the opportunity to make a submission to this Inquiry and for considering our recommendations. We would be pleased discuss our submission in further detail.

The Dementia Australia Policy and Advocacy team can be contacted via **policyteam@dementia.org.au**

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